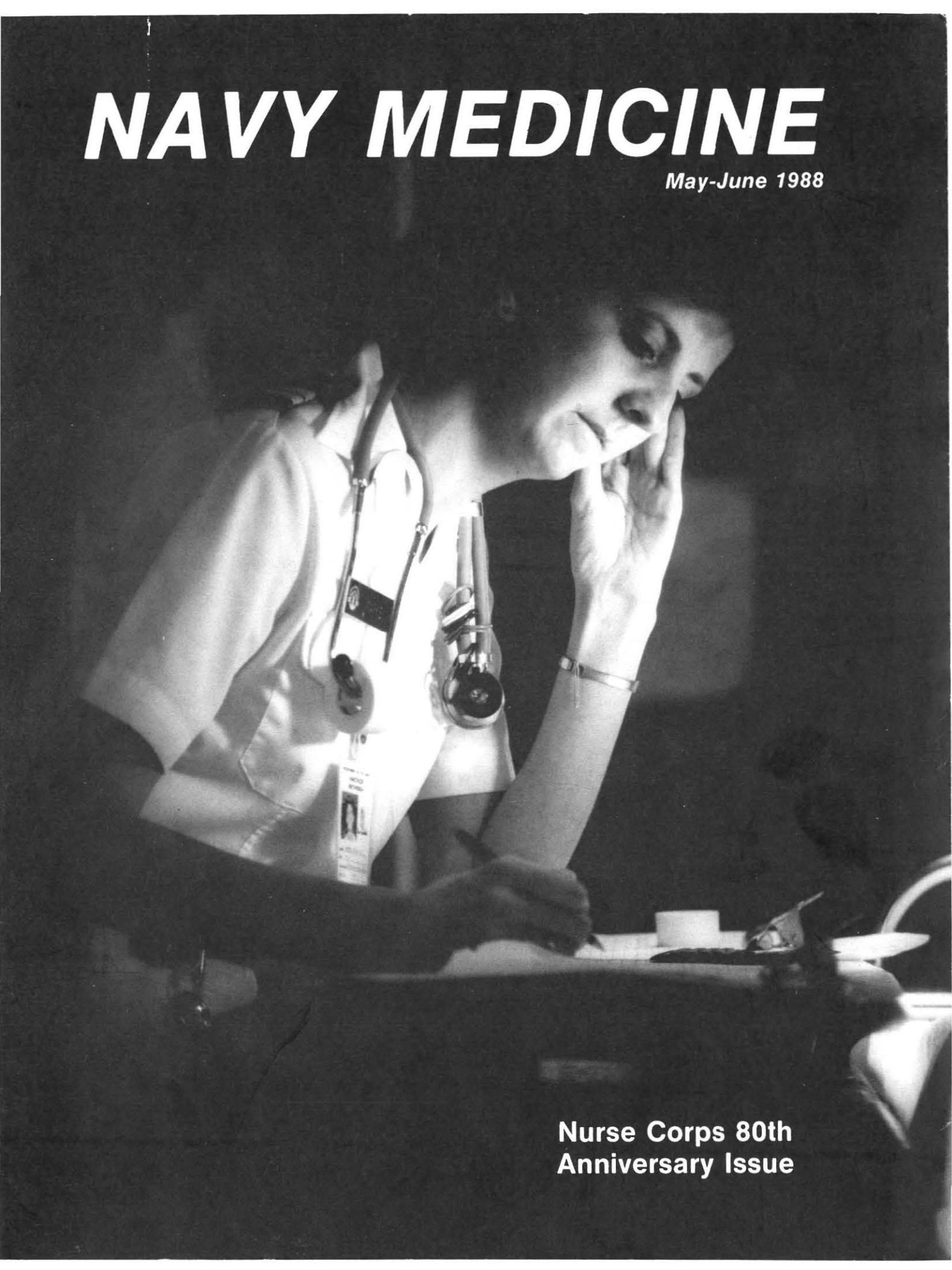
NAVY MEDICINE

May-June 1988



Nurse Corps 80th Anniversary Issue

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COVER: LT Carol Marks, NC, completes TPR (temperature, pulse, respiration) recordings on her patient at Naval Hospital, Bethesda, MD. This year dedicated professionals of the Navy Nurse Corps celebrate the corps' 80th birthday. Photo by HM3 Louis E. Curtis, Jr., NSHS, Bethesda, MD.

80 Years of Caring

The 80th anniversary of the Navy Nurse Corps comes at an important time in the history of medicine in the Navy and Marine Corps, and at an equally important time in the history of nursing as a profession. Never before has nursing provided such a sophisticated and broad range of services to medical practice as it does today. That nursing skills have become an increasingly critical part of the spectrum of medical practice is evidence of the deep and continuing professional commitment of generations of nurses to the growth and expansion of their service to and involvement in the healing arts.

In the Navy and Marine Corps, nurses have been at the leading edge of clinical practice and the innovators of both clinical and management skills to meet the changing needs of a rapidly changing Medical Department. No challenge has been left unanswered as burgeoning training requirements brought more nurses into that important area of endeavor. The quality assurance program, which accompanied the growth of clinical complexity, owes much of its thoroughness and effectiveness to a generation of nurses who established and honed it into a standard now widely accepted throughout the nation.

Above all, generations of Navy nurses in peace and war have excelled in the most critical and important skill of all, the direct contribution to successful patient care in a wide variety of challenging environments at sea, ashore, and overseas around the world. Navy medicine today depends as never before on the dedication and competency of its Nurse Corps. In turn, I am personally committed to the growth and professional viability of the Nurse Corps and its people, including timely advancement, continuing education, and improved professional environment.

We do not have enough nurses on board, a serious problem which makes more difficult the lives of those who already give more than their share of care and caring. Commitment must be rewarded with commitment in return, especially when that clear and sterling record has spanned eight decades of exemplary service. Navy nursing has never been better, brighter, or more capable. My personal commitment is to help keep it that way.

VADM James A. Zimble, MC

Nurse Corps Celebrates 80 Years

Eighty years of nursing in the Navy, and the 80th anniversary of the establishment of nursing as a corps in the Medical Department, is not just another anniversary.

By its nature and inherent demands, nursing is already one of the most challenging professions known to man. Only people of dedication, energy, and commitment can practice it to its fullest measure. At the same time, the many added dimensions of practicing medicine in the military environment bring new and greater challenge. In the Navy and Marine Corps, nursing is an all-environment practice, from shore to sea, to overseas and in the air; wherever sailors and marines are present, nursing is there with skill and innovation. From hospital ships to fleet hospitals, to the Arabian Gulf and the Indian Ocean, the Navy Nurse Corps is there.

Just as the geographic range of Navy nursing has never been wider, so, too, have the professional nursing skills expanded rapidly in range to parallel the dramatic progress of medicine in its many fields. Navy nurses have been consistent leaders in innovation, teaching, and the great process of professional broadening which the nursing profession as a whole has experienced during the past several decades.

The challenge continues to grow, from generation to generation, a factor which is recognized in the Navy, and which we must reward in recognition of its enormous merit and the clear need to keep Navy nursing viable and growing in the future. Navy medicine and the Nurse Corps grow together, as grow we must in the years to come. The challenges of today, and there are many, will be conquered and give way to the newer challenges of tomorrow. When those challenges become history, Navy Nurse Corps officers, as they consistently have in the past, will be part of the solution.

RADM Joseph S. Cassells, MC

LT Karen Kreutzberg, NC, of Naval Hospital, Bethesda, confers with one of her patients. Photo by HM3 Louis E. Curtis, Jr.


KREUTZBERG

Flag Officer Selectees

RADM-selectee **Robert B. Halder**, MC, deputy commander for fleet readiness and support at the Naval Medical Command, Washington, DC, since November 1987, is a native of Oneida, NY. He graduated from the State University of New York, Harpur College in 1964 and received his M.D. degree from the State University of New York Upstate Medical School in Syracuse, NY, in 1968. He served as a surgical intern at the State University of California, University Hospital, San Diego, CA, from 1968 to 1969.

CAPT Halder entered the Navy in 1969 as a student flight surgeon at the Naval Aerospace Medical Institute in Pensacola, FL, and upon graduation was assigned to Helicopter Training Squadron (HT-8) at Ellyson Field in Pensacola. He then entered the Ophthalmology Postgraduate Training Program at Naval Hospital, San Diego, CA, in 1971. Following a tour of duty in Harar, Ethiopia, in a Joint International Eye Foundation, he completed his ophthalmology residency in August 1974.

Subsequent assignments included staff ophthalmologist and family practice preceptor, Naval Hospital, Camp Pendleton, CA; director of clinical services, Naval Hospital, Camp Pendleton (1983); executive officer, Naval Hospital, Long Beach, CA (1984); and commanding officer, U.S. Naval Hospital, Naples, Italy (1985-1987).

CAPT Halder is a member of several professional organizations and a fellow of the American Academy of Ophthalmology. His military awards include the Legion of Merit, Navy Commendation Medal, Navy Achievement Medal, Meritorious Unit Commendation, National Defense Medal, Humanitarian Service Medal, and Overseas Service Ribbon.

RADM-selectee **Harold M. Koenig**, MC, commanding officer at the Naval Health Sciences and Training Command, Bethesda, MD, was born 28 Feb 1940 in Salinas, CA. He attended the U.S. Naval Academy from 1958-1959 and graduated from Brigham Young University in 1962.

CAPT Koenig was commissioned a lieutenant 1 Dec 1965 and received his M.D. degree from Baylor University College of Medicine in Houston, TX, on 10 June 1966. He completed a pediatric internship at Ben Taub General Hospital and Texas Children's Hospital, Houston, in June 1967, and was named the Outstanding Pediatric Intern for that year by the medical staff.

Following his internship he served as general medical officer, fleet activities, Sasebo, Japan, from 1967 to 1969. He then reported to Naval Hospital, San Diego for pediatric residency from 1969 to 1971 and where he received a fellowship in pediatric hematology-oncology from 1971 to 1973. After completing training CAPT Koenig remained in San Diego as head of the pediatric hematology-oncology division, training three additional fellows in this subspecialty.

Subsequent assignments included chief of pediatrics, Naval Regional Medical Center, Oakland, CA (1980); director of medical services, Naval Hospital, Oakland (1983); executive officer, Naval Hospital, Portsmouth, VA (1984); and commanding officer, Naval Hospital, San Diego, CA (1985-1987).

CAPT Koenig is certified by the American Board of Pediatrics and the American Board of Pediatrics Sub-Board of Pediatric Hematology-Oncology. He is a member of the American Society of Hematology, Western Society for Pediatric Research, Society for Pediatric Research, American Academy of Pediatrics, and Association of Military Surgeons of the United States. He received the Ogden C. Bruton Award for Outstanding Military Pediatric Research in 1970. He holds the Secretary of the Navy Achievement Award, two Meritorious Service Medals, and Legion of Merit.

CAPT Robert B. Halder, MC

CAPT Harold M. Koenig, MC

RADM-selectee **Charles R. Loar**, MSC, commanding officer at the Naval Hospital, Bethesda, MD, is a native of Ashland, KY. He enlisted in the Navy as a seaman recruit and advanced to yeoman first class. While maintaining an active reserve status, he received his B.S. degree from Marshall College, Huntington, WV, and his M.B.A. degree from the University of Florida. He completed postgraduate work at George Washington University.

CAPT Loar was commissioned an ensign in the Medical Service Corps in August 1965 and was the first officer in the corps to attain the rank of fellow in the American College of Healthcare Executives (ACHE). For 8 years he served as the Navy representative for the Regent-at-Large of that organization.

Subsequent assignments included Medical Service Corps plans officer, Naval Medical Command, Washington, DC; director of administration, Naval Hospitals Oakland, CA, and Orlando, FL; assistant to the executive officer, fleet medical liaison officer, and regional health care coordinator, National Naval Medical Center, Bethesda, MD; director, health care administration division, director, quality assurance division, and special assistant to the Surgeon General for health care administration, Bureau of Medicine and Surgery, Washington, DC; and commanding officer, Naval Hospital, Corpus Christi, TX.

In addition to his active participation in the ACHE, CAPT Loar is a member of the Interagency Institute for Federal Health Care Executives Alumni Association and the Association of Military Surgeons of the United States. He also serves as an advisor to the Board of Regents, Uniformed Services University of the Health Sciences. In January 1985 he was elected to the House of Delegates of the American Hospital Association. He is the only military member of the House, the highest legislative body of the association. He was named the 1985 Outstanding Federal Services Administrator by the Association of Military Surgeons of the United States.

CAPT Loar's military awards include the Legion of Merit, Meritorious Service Medal with Gold Star, Navy Commendation Medal, Navy Achievement Medal, Naval Reserve Meritorious Service Medal, and Armed Forces Reserve Medal.

RADM-selectee **Ronald P. Morse**, DC, on the staff of Commander, Naval Medical Command, Southwest Region, was born 1 Sept 1933 in Buffalo, NY. He attended the University of Washington and received a B.S. degree in psychology in 1955 and a D.D.S. degree in 1959.

During his senior year in dental school he was placed on active duty as an ensign in the Senior Dental Student Program and immediately upon graduation was augmented into the regular Navy and promoted to lieutenant, junior grade.

Following his first assignment at Naval Security Group Activity, Kamiseya, Japan, in July 1959 CAPT Morse had duty at the San Francisco Naval Shipyard.

Subsequent assignments included dental officer, USS *Klondike* (AR-22); assistant dental officer, U.S. Naval Academy; dental officer, USS *John F. Kennedy* (CV-67), where he was selected Officer-of-the-Year; director of clinical services, Naval Regional Dental Center, San Francisco, CA; officer-in-charge, branch dental clinics, United Kingdom, London, England, with additional duty as fleet dental officer on the staff of Commander-in-Chief, U.S. Naval Forces Europe; executive officer, Naval Dental Clinic, San Diego, CA; assistant chief of staff for dentistry, Naval Medical Command Pacific Region; commanding officer, Naval Dental Clinic, Pearl Harbor, with additional duties as fleet dental officer, CINCPACFLT, and force dental officer, COMNAVLOGPAC and COMSUBPAC; and commanding officer, Naval Dental Clinic, San Diego, CA, the Navy's largest dental command.

CAPT Morse is a member of numerous professional organizations including the American Dental Association, Academy of Operative Dentistry, Academy of General Dentistry, Association of Military Surgeons of the United States, and is a fellow in the International College of Dentists. He wears the Legion of Merit, Meritorious Service Medal with Gold Star in lieu of second award, Meritorious Unit Commendation Ribbon, Navy "E" Ribbon, National Defense Service Medal, Sea Service Ribbon, Overseas Ribbon, and Navy Expert Pistol Medal. □

CAPT Charles R. Loar, MSC

CAPT Ronald P. Morse, DC

New Life in Ward C

The swish of a door awakens one from a deep sleep and the shuffle of feet in the hallway means someone is approaching. Wondering how in the world it could already be "that time" again, there is a sigh of relief as the footsteps pass the door and fade down the corridor.

Becoming a new mother can be exhausting anywhere, but at the Naval Hospital, Naval Air Station, Lemoore, CA, a group of dedicated professionals help new moms get a gentle start. Ward C, or the "Maternity Ward," is staffed with eight Navy nurses and 18 hospital corpsmen working three shifts. A licensed vocational nurse (LVN) works in the nursery at nights.

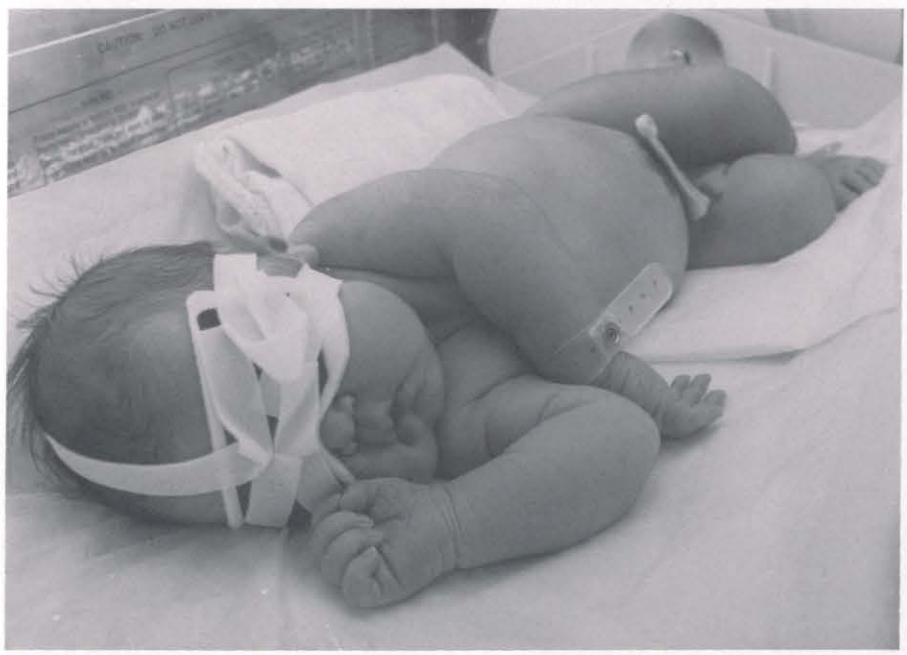
It is a busy ward. An average of 40 deliveries and 40 nonstress tests (NST's) are administered monthly. "NST's are ordered by a doctor for high-risk pregnancies, women who have high blood pressure, gestational diabetes (only during pregnancy), diabetics, or problems with previous pregnancies," explains LT Maurice Gregory, NC.

"The monitor registers the heart rate of the baby during movement and shows the doctor how the baby will handle the stress of birth. The same machine is used during actual labor to monitor the child's heart rate and the mother's uterine movements (contractions)."

Patients requiring NST's generally have the tests done once or twice a week during the last 3 months of pregnancy. The test takes between one-half hour to 1 hour and Ward C staff monitors the progress. If the baby isn't moving, juice with sugar in it is given to the mother. This activates the fetus into movement.

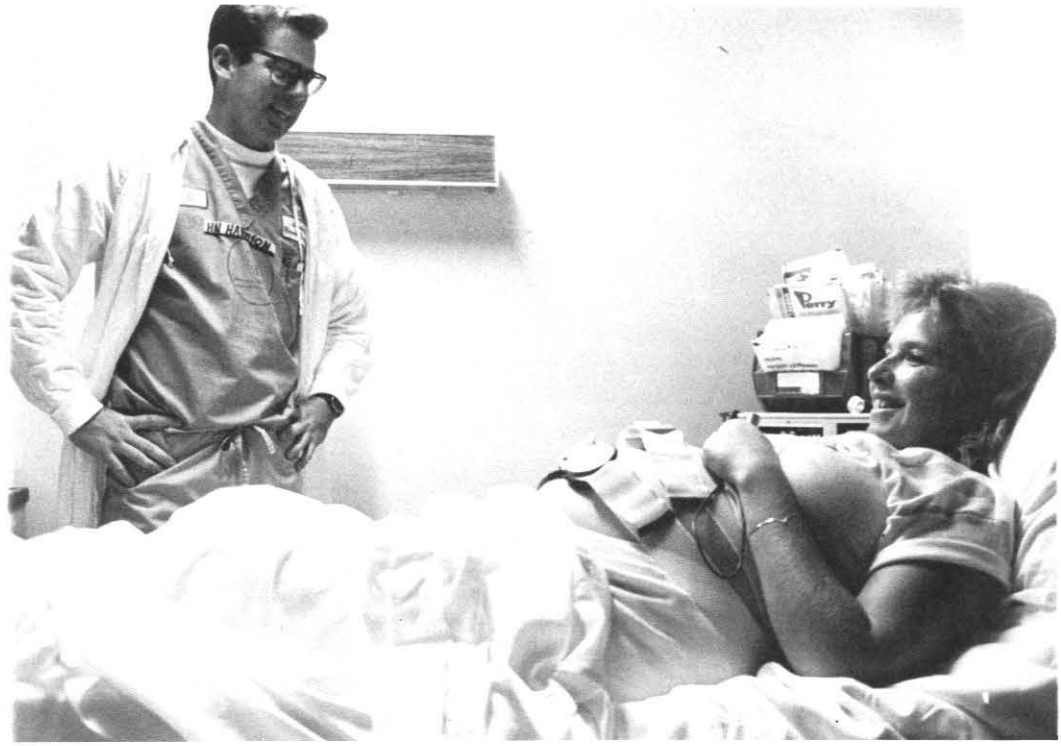
Corpsmen and nurses assist doctors during the deliveries and are responsible for the aftercare of mother and child, both who must stay a minimum of 48 hours.

Brandy Bell receives phototherapy.



"The first hour after birth is one of the busiest for the newborn," says LT Maureen Rogers, NC. "Babies must be bathed, weighed, measured, have ointment placed in their eyes, and given a vitamin K shot. First feedings are also done within the hour either from the mother or us, if the mother's not able."

The newborn's vital signs are watched closely in the first 24 hours and then taken every 4 hours. A daily record is kept of the babies' weight, body functions, and amount of food they eat. This is passed on to each shift during the "changing of the guards" briefing. The mothers' recovery progress is also recorded.



HN Kenneth Harrison monitors Karan Beard's progress during a nonstress test.

"Forty-eight hours after the first milk feeding, a phenylketouria (PKU) test is administered," says LT Emily Baughman, NC. "This determines if the baby is compatible with the protein in the milk, bottle, or breast."

During the first week of life, about 50 percent of babies born at term and 75 percent of premature infants, develop a common condition called physiologic jaundice. This occurs when bilirubin, a pigment formed in the normal breakdown of red blood cells, accumulates in the body. If the bilirubin level is higher than normal or remains elevated for a prolonged period, an infant may require phototherapy.

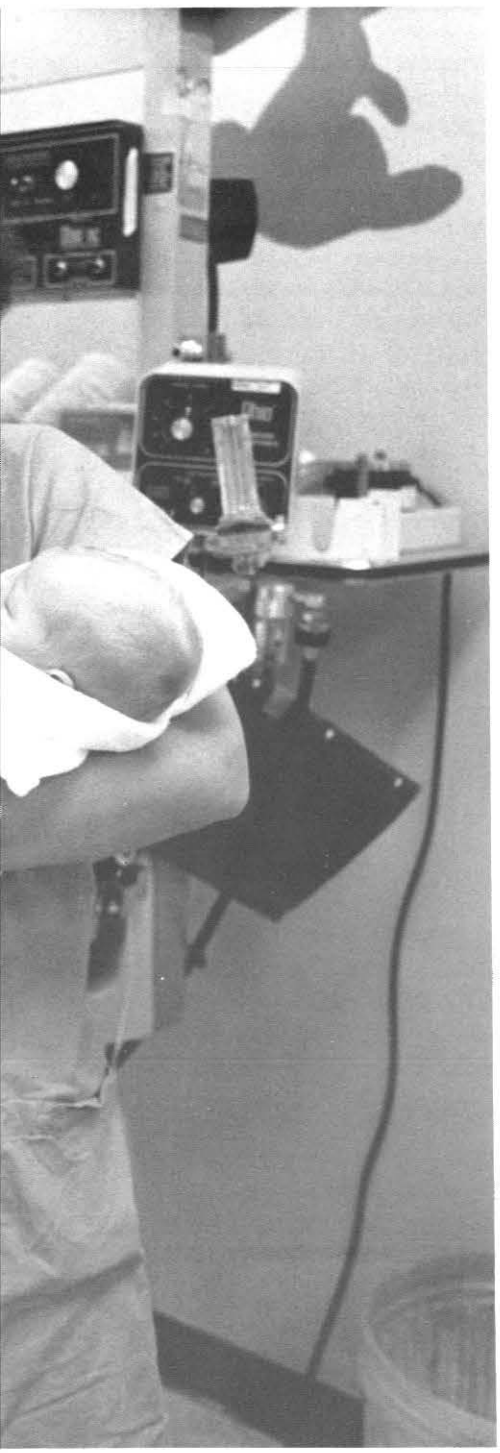
Lori Bell's baby girl required this treatment. "When I first saw Brandy in the incubator under bright lights I was worried," says Lori. "But I'm thankful that it wasn't as serious as it looked and I would like other mothers to know this could happen to their baby." Treatment involves placing the infant under bright lights to change the bilirubin to a water-soluble form that is easily excreted. This enables their systems to be cleaned.

But babies are not the only ones Ward C helps to get started on the right foot. Corpsmen and nurses instruct mothers in bathing procedures, diapering, care of the umbilical cord and circumcisions, and offer helpful hints on feeding schedules.

Sibling visits are encouraged in order to introduce the new member to the whole family. The hospital staff feels it is important to include younger children from the beginning to help ease the adjustment at home.

When the time comes for patients to go home, corpsmen take the infants in their carseats to the patients' vehicles and secure them in place for the trip. Now it's up to mom, dad, and baby. □

—Story and photos by JO3 Cyndi Reilly, Public Affairs Office, NAS Lemoore, CA.



LT Diana Holmes gives Stephen Nadolny one of his first meals.

A Conversation With RADM Hall

RADM Mary F. Hall, 16th director of the Navy Nurse Corps and deputy commander for personnel management, is at the top of her career. In 1983, when she took charge of Naval Hospital, Guantanamo Bay, Cuba, she became the first Nurse Corps officer to command a naval hospital. Two years later RADM Hall took command of Naval Hospital, Long Beach, CA. She holds a B.S. degree in nursing from Boston University and an M.S. in nursing service administration from the University of Maryland.

Her previous assignments included nursing positions at the National Naval Medical Center, Bethesda, MD; Naval Hospital, St. Albans, NY; Naval Hospital, Guam; Naval Regional Medical Center, Camp Lejeune, NC; Naval Regional Medical Center, Portsmouth, VA; Naval Hospital, Quantico, VA; Bureau of Medicine and Surgery, Washington, DC; and Naval Regional Medical Center, Newport, RI.

Among her many decorations, RADM Hall wears the Legion of Merit, Meritorious Service Medal with two gold stars, Navy Commendation Medal, Navy Unit Commendation Ribbon, and National Defense Medal. She is a member of the National Association for Female Executives, Inc., National League for Nursing, Sigma Theta Tau, National Honorary Society-Nursing, and Association of Military Surgeons of the United States.

Navy Medicine *recently talked with RADM Hall on the occasion of the Nurse Corps' 80th birthday.*

Photos by the Editor

NAVY MEDICINE: You were the first Nurse Corps officer to command a naval hospital. Do you have any special thoughts about that distinction?

When I joined the Navy in the fifties I watched each succeeding decade mark significant progress in our profession. When the reorganization came about in 1982 the decision was made to go for the best qualified. I thought the concept of allowing the best qualified to lead was a superb idea, not knowing that I would be selected as one of those pioneers who would implement the changes. Being a nurse and having command at the Naval Hospital in Guantanamo was a very positive experience. Being a small base, I had only 186 people on my staff. We had a very simple focus—to support the fleet and the Marines. There weren't many outside distractions. By the time my 2 years were up, the fanfare had died down and I moved very quietly to Long Beach for my second command. By then no one was paying much attention to whether I was a woman or a nurse.

What else made Guantanamo so memorable?
There were 7,000 personnel on the base and we were responsible for all of them. The base was unique in that all the services were represented—Air Force, Army, Navy, Marine Corps, and even Coast Guard. It was quite a transition going to Long Beach. I suddenly went from 186 staff members and less than 50 operating beds to a hospital with about 170 beds. In addition, I had also inherited six clinics and some 1,300 personnel.

You wear two hats, Deputy Commander for Personnel Management and Nurse Corps Director. How do you handle both jobs?
With an extended workday. I'm in the office by 6:30 a.m. I meet with Nurse Corps officers from 7:00 to 8:00, and I'm available from 8:00 on for my role as deputy commander. I then meet again with my nurses in the late afternoon or early evening.

Do you miss the personal patient contact you once enjoyed?
Sure I do. But I take field trips and make rounds. I go to where the patients and staff are and afterward meet with the commanding officer and all the nurses. Almost all my field trips include ambulatory and inpatient areas, where I talk to the crews and the patients. I then come back and examine every single policy, procedure, and instruction to see whether they are needed.

What makes Navy nursing different from civilian nursing?
In the course of a career, a Navy nurse can expect to operate in a number of vastly different environments. There are few, if any, civilian nurses who would go from a tertiary care facility

to a hospital ship or a fleet hospital. If war broke out, they could move from a CONUS hospital to a combat zone and be expected to perform advanced emergency procedures in what could be considered a primitive environment. When nurses deploy with a fleet hospital they live in a GP (general purpose) tent and sleep on cots.

How are they prepared for this eventuality?
Nurses and the corpsmen they are responsible for training move through a continuum ranging from battalion aid stations and ships' sickbays all the way back to tertiary care facilities. We train them to work anywhere in that continuum. And that training must be environment-specific. We send nurses to C-4 (Combat Casualty Care Course) to learn about treating patients in the field. This and other training exercises prepare them to use those skills. And, of course, a Navy nurse not only practices clinical medicine but is a naval officer as well.

I have heard you refer to the circle of care concept before. What exactly does it mean?
The circle of care concept is another thing that makes military nursing unique. In the circle of care, the patient is at the center. Then there are the three players who constitute the treatment team—the physician, the nurse, and the corpsman. Each member contributes special skills in order to treat that patient's illness or injury.

What is being done to address the Navy's nursing shortage?
As you know, the shortage is not confined to the Navy. It is nationwide.

Knowing what to do about it requires some background. In the fifties the two professions women went into most were teaching and nursing. In the late sixties and early seventies huge numbers of women rejected teaching and flowed from that field. Although the eighties seems to be the decade for the health care field, many women have rejected nursing as a career in favor of going to medical school. In fact, 40 percent of medical school enrollment is female. Nursing enrollment has dropped so dramatically that many nursing schools have already closed. As the supply has dropped off, the demand for nurses is growing by leaps and bounds. HMO's, insurance companies, and stand-alone clinics are gobbling them up in huge numbers.

How does the Navy fit into this seemingly bleak picture?

We in the military have always offered a special kind of nursing and therefore we remain highly competitive, even with shrinking resources. There may be a lot of jobs in the civilian sector but we offer a career, a special combination of two professions. People can still focus primarily on patient care but they can also have all the status and prestige of being an officer. There may be over 250 million people in the country, yet there are only 3,000 active duty Navy nurses, making us a fairly exclusive club.

HM3 Louis E. Curtis, Jr.

ENS Leslie Meslin performs a blood gas procedure on a patient in Naval Hospital, Bethesda's ICU.

What about retention?

It's usually in the first 3 or 4 years that a nurse decides whether career goals are compatible with a military lifestyle. And then the decision is made to stay or leave. We do have losses at that lower level. All companies do. Once

PH2 Bryan Peppers

Making rounds is an important part of the Nurse Corps director's job. Here RADM Hall admires young Megan Sweeney while on a visit to Naval Hospital, Patuxent River, MD.

nurses go past 6 or 8 years the numbers who choose to make it a career grow significantly. The Nurse Corps is becoming a corps of advanced specialists that parallels very much what happened to the Medical Corps 10 years ago. If you have a corps with a baccalaureate entry level, within 10 years you're training them at a master's level. The maximum productivity of those officers is going to be from the 14th to the 30th year. In order to retain them you have to be able to promote them. That's why we're requesting DOPMA relief.

What is the current shortage?

We are authorized 3,200 and have 3,039 on board.

I understand that males now comprise almost 25 percent of the corps.

Yes. Twenty-five percent of our members are male and that adds to our strength. In the civilian world male nurses number less than 2 percent. In addition, there are no restrictions on how we utilize our male Nurse Corps officers. They can work in any clinical setting doing any kind of patient care. Therefore, there's very strong incentive to remain. They can experience clinical development as professionals and also have careers as naval officers.

How do you feel about the nurse co-op program as a means of obtaining nurses?*

I feel very good about it. In fact, we are in the process of expanding the program to include Guam. One of the real strengths of the Nurse Corps is its incredible diversity. We come from all parts of the United States, from very different social and economic backgrounds, and from all kinds of educational philosophies.

We see the co-op as a very positive way of bringing minorities in from Puerto Rico and Guam. It also provides significant career mobility for those who are involved. It's good for the corps and good for the students. Everybody wins. I might remind you that we have another program we're very proud of—the Medical Enlisted Commissioning Program. It provides a 2- to 3-year nursing school education. We send about 25 students per year. Each student is then obligated for 4 years' service following graduation. To date we've commissioned 32 students and will graduate 17 this year. We feel that every nurse we recruit must be individually selected and individually developed. They must understand who we are and what we do. Those who are planning to stay for the long haul must meet professional standards to satisfy both clinical and officer roles. Needless to say, we are very choosy. You know the telephone company commercial that tells us to reach out and touch someone. Navy nurses must be prepared to do that every day. —JKH

*See "Nurse Co-Op: A New Source for Navy Nurses," page 16.

The Navy Nurse Corps

Eighty Years of Service, Professionalism, and Spirit

LCDR Margaret Barton, NC, USN

What makes the Navy Nurse Corps and its over 3,100 active duty membership so unique? How does the Navy Nurse differ from his or her civilian counterpart? Why remain in the Navy Nurse Corps? Why encourage others to join? These and other questions were asked of a group of active duty Nurse Corps officers stationed throughout the United States. Although their clinical interests, educational backgrounds, individual ranks, and current assignments vary, each officer's response carried with it a common theme: "The personal and professional benefits of the Navy Nurse Corps remain unequaled."

LT Kathleen Pierce

After working as a civilian nurse for almost 2 years upon graduation from a baccalaureate nursing program, LT Kathleen Pierce decided on a commission in the Nurse Corps. Following her initial tour at Naval Hospital, San Diego, LT Pierce was sent to Naval Hospital, Okinawa, Japan, where she worked as a staff nurse in the intensive care unit. Shortly after being transferred to Naval Hospital, Oakland, LT Pierce was selected to accompany the USNS *Mercy* on its humanitarian cruise throughout the Pacific where she served as charge nurse of one of four 20-bed intensive care units. Upon her return to Naval Hospital, Oakland, she was first assigned as the assistant charge nurse of the intensive care unit and in January of this year became the charge nurse. Comparing her nursing experiences thus far with those encountered by civilian nurses she knows, LT Pierce feels that many of her civilian colleagues are already experiencing "burn-out" and leaving the profession. "What I like most about the Navy Nurse Corps has been the many opportunities provided which allow me to share my knowledge. I have greatly appreciated the fact that my opinion as a registered nurse *matters* and that I have direct input into the care of the wide variety of patients we see. The Navy has allowed me to grow, to develop myself further not only as a nurse but as a naval officer." When asked what her 80th anniversary message is for the Navy Nurse Corps, LT Pierce stated: "We as a professional group have accomplished a great deal over the years, and, of course, have much more to achieve. Many times, we do not see the impact of our work—how our work touches others. My experiences on the hospital ship taught me a lot about our worth as members of the Navy health care delivery team. Although 'negativism' on the part of others is really easy to absorb right now, it is also the easiest path to take. All the friends I have made, all the things I have accomplished pretty much balance out the 'bad days' for me."

LT Kathleen Pierce

LTJG Janice Harrell

LTJG Janice Harrell

Following a 3-year tour on active duty in the Air Force Nurse Corps, LTJG Janice Harrell resigned her commission and worked as a civilian nurse for several months. Dissatisfied with what she perceived as a lack of camaraderie in the civilian nursing sector, LTJG Harrell took the advice of several Navy Nurse Corps friends and joined their ranks. Since last December she has served on active duty in the Navy Nurse Corps and currently works as a staff nurse on an orthopedic ward at Naval Hospital, Camp Pendleton. Commenting on her present work environment, LTJG Harrell states: "There is such a sense of pride here. It comes from working with such good people!" Prepared at the baccalaureate level in nursing, she returned to school on a part-time basis and took classes toward completion of a master's degree in health care administration. Excited about the possibility of going overseas following her current assignment, she would like to gain additional experience in either the intensive care unit or emergency department. Her 80th anniversary message to the Navy Nurse Corps is brief and to the point: "Stick with the Navy, you can't go wrong. Not only are we having an adventure, we are leading one as well."

LT Jo Ann Critelli

Convinced that her 7 years experience as a "seasoned civilian RN" could and would be best utilized by the Navy Nurse Corps, LT Jo Ann Critelli decided to join the Navy. Initially assigned to Naval Hospital, Bethesda, LT Critelli worked on a neurosurgical ward, a medical-surgical ward, then the emergency room and clinics area. Currently assigned as a staff nurse in the intensive care unit at NAS Corpus Christi, TX, she also works as relief night supervisor, quality assurance coordinator, and schedule coordinator. "The wonderful thing about the Navy Nurse Corps is that you find yourself in a variety of settings and on the receiving end of a multitude of experiences. I have never felt bored, slighted, or underchallenged. My supervisors and co-workers listen to one another's ideas which makes me feel good. I like the idea of role modeling and leadership development being important and encouraged in the Nurse Corps. I did not find this to be the case in my civilian nursing experiences." Certified in Advanced Trauma Life Support and Emergency Room Nursing, LT Critelli hopes to one day serve aboard a hospital ship or be a corps school instructor. LT Critelli's 80th anniversary message to her fellow Nurse Corps officers is: "Birthdays are for celebrating. Each and every Navy nurse should take a minute and examine the special uniqueness of their chosen career. It takes a highly motivated, technically skilled, and honestly dedicated professional to meet the exciting challenges that the Navy provides. Nothing equals the pride and sense of accomplishment experienced knowing that the highest level of nursing care is being delivered on a daily basis by each and every Nurse Corps officer."

LT Jo Ann Critelli

LCDR Debra Janikowski

As a clinical instructor for the emergency department and 13 of the ambulatory care clinics at Naval Hospital, Bethesda, LCDR Debra Janikowski willingly admits to "keeping busy" with implementing the orientation and in-service programs for all nursing service personnel assigned to these areas. A "veteran" Nurse Corps officer of 12 years, LCDR Janikowski worked as a civilian RN for almost 2 years before deciding to join the Navy. "Twelve years ago, the upward mobility for nurses was not that great in civilian nursing and the pay was not much better. I originally came into the Nurse Corps for the experience, the travel, and the schooling. I also came in for the increased responsibilities and accountability. I think that there are more jobs available for nurses now on the outside, but I still feel that the recognition, responsibility, and accountability continues to be greater

in the Navy Nurse Corps." Prior to coming to Bethesda, LCDR Janikowski was assigned to an operational billet for 14 months with the Third Force Service Support Group in Okinawa, Japan. "My ultimate goal is to return to operational nursing after completing a master's degree in trauma/emergency nursing. This is my primary interest and it is where I feel that I can contribute the most in meeting the mission of the Navy Nurse Corps." On her own time, LCDR Janikowski has been attending school and last year was selected for full-time duty-under-instruction to complete the requirements for a baccalaureate degree in nursing. Her 80th anniversary message to the Navy Nurse Corps is this: "In light of the fact that we are facing difficult times in terms of limited resources and decreased promotion opportunity, I think we each need to support one another to facilitate the unity and spirit that has existed throughout our history. This is essential for the continuation of the Nurse Corps. I am optimistic that our future is a promising one. We can't wash our hands of the problems and turn away—the problems we face are simply not going to disappear that easily. We simply must work more closely together and continue to give our usual 110 percent!"

LCDR Debra Janikowski

LCDR Nancy Owen

Nominated 10 years ago by her command to be featured in a *U.S. Navy Medicine* article about the Navy Nurse Corps, LCDR Nancy Owen was characterized then as having a "unique ability to inspire peers and subordinates to increase their knowledge and skill and function to the fullest extent of their potential." Having served in the Nurse Corps for 15 years, Owen is presently assigned to the Naval Hospital, Philadelphia where she works as the department head for ambulatory care nursing. She began her naval career at Naval Hospital, Charleston and was subsequently assigned to Naval Hospitals, Portsmouth and Subic Bay. Following her tour overseas, LCDR Owen was assigned full-time duty-under-instruction to complete her baccalaureate nursing degree, and was then assigned to the Naval Hospital in San Diego prior to coming to Philadelphia. "At the time I entered the Nurse Corps, I focused heavily on developing my clinical nursing skills in a variety of patient care areas. After I went back for my baccalaureate degree, I felt I had brought my knowledge level up to match those particular skills and so I began to concentrate on developing myself in a specialty area. For me, that was coronary care nursing. While working as charge nurse of the coronary care unit at Naval Hospital, San Diego, I obtained my critical care certification and my advanced cardiac life support certification." As department head of ambulatory care nursing at Naval Hospital, Philadelphia, LCDR Owen feels she has had the opportunity to develop further her administrative and managerial skills. Because of the "ups and downs" that the hospital has been through over the past few years, she also has the rather unique collateral duty assignment as public affairs officer. Selected once again for full-time duty-under-instruction, LCDR Owen will be returning to school to earn her master's degree in critical care nursing. "It has always meant a lot to me to have a supervisor with the knowledge, experience, and

LCDR Nancy Owen

educational background in the area I was working. It adds to their credibility and allows them to really serve as a resource for their staff. I hope to be that kind of person when I complete my graduate program." Owen's 80th anniversary message to the Nurse Corps is two-fold: "The basis for our existence continues to be the patient. Regardless of our technical training and clinical expertise, the most important act we carry out is our one-to-one contact with that patient. I would wish that all Navy nurses and corpsmen remember this very fundamental point. I would also encourage more junior Nurse Corps officers to stay in and persevere the 'rough times' we currently face in terms of promotion opportunities. I feel Navy nursing is an excellent career choice. We are held in high esteem by others both inside and outside our organization because of our clinical competence and leadership abilities. I would encourage others to 'hang in there' as there are many rewards to be found in the Nurse Corps."

LT Doris J. Safran

LT Doris Safran originally entered the Navy in 1970 as an enlisted woman. After completing operating room technician school and working

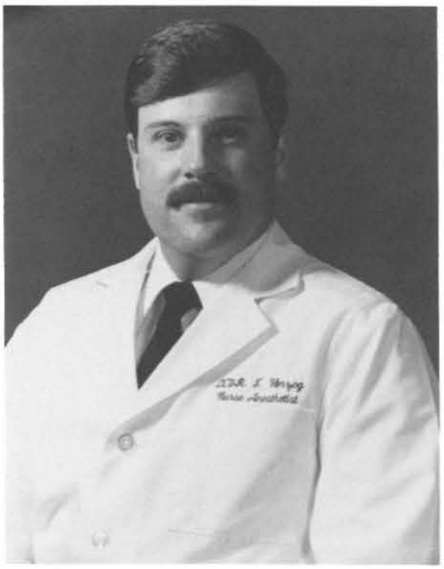
as an operating room technician, she was accepted into the Navy Enlisted Nursing Education Program (NEN-EP), and was sent to a baccalaureate nursing program to complete her basic degree in nursing. Following her first tour as an officer at Naval Hospital, Portsmouth, LT Safran was stationed at Naval Hospitals, Philadelphia and Keflavik, and Naval Medical Clinic, Quantico. Currently assigned to Naval Hospital, Jacksonville, Safran works as the charge nurse of the operating room where she oversees seven nurses and approximately 25 operating room technicians. While stationed at Naval Hospital, Jacksonville, she has completed a master's degree in health care administration and was selected for lieutenant commander. "I joined the Navy approximately 18 years ago for the educational benefits, the travel opportunities, and because I wanted to serve my country. I sought out the Nurse Corps because the dual role of being an officer *and* a nurse has always appealed to me. This in itself requires the development of a broad range of skills and knowledge. The fact that Navy nurses are viewed as a more integral part of the health care delivery team was also very appealing. Navy nurses are *expected* to be leaders, teachers, and role models at an early stage in their professional development. Civilian nursing colleagues talk to me about their quest to be treated as professionals. We have already achieved this in the Navy Nurse Corps." LT Safran's 80th anniversary message to the Nurse Corps is: "Just as the Navy Nurse Corps is growing and maturing, so should each individual Navy nurse. I would hope that none of us waste the many unique opportunities available to us as Nurse Corps officers and that we take responsibility for our own professional growth and development. We need to guide, encourage, counsel, and support one another and those we lead so that all can continue to grow and develop as vital, contributing members of the Navy health care delivery team."

LT Doris J. Safran

LCDR Todd Herzog

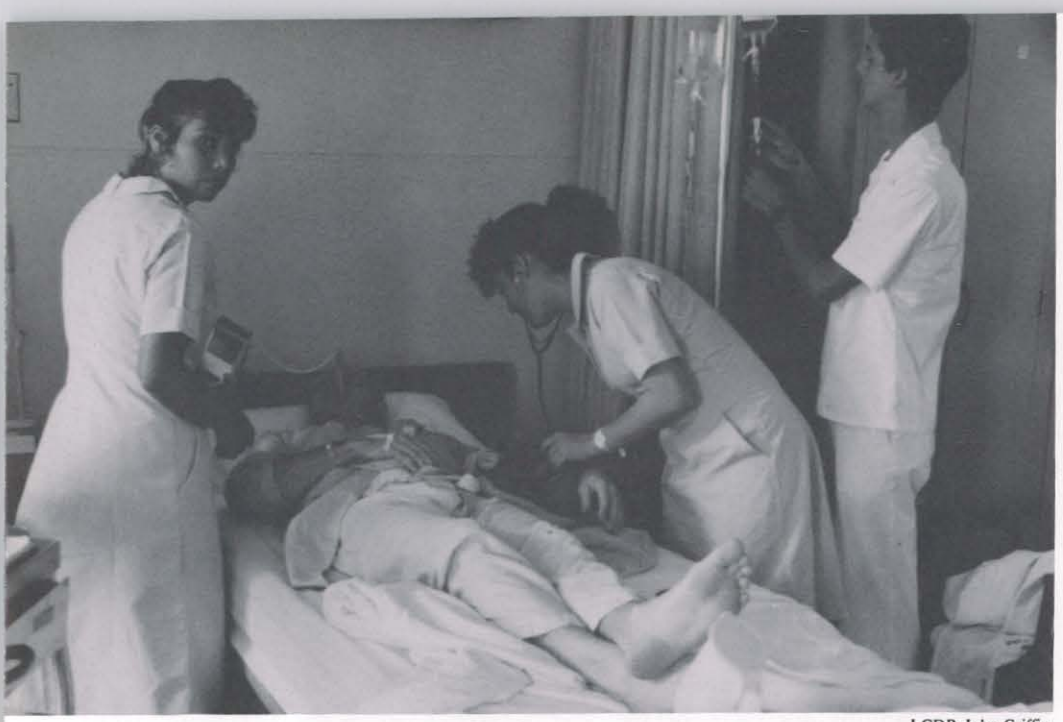
LCDR Todd Herzog describes himself as a product of the Navy Enlisted Nursing Education Program following a 4-year enlistment as a Navy corpsman. After approximately 7 years of working both stateside and overseas as an intensive care unit staff nurse and charge nurse, LCDR Herzog applied for the Nurse Anesthetists Program. Following completion of the didactic portion of this program at George Washington University and the clinical training portion at Naval Hospital, Portsmouth, Herzog was assigned as a staff nurse anesthetist at Portsmouth and then as assistant clinical coordinator for nurse anesthesia school at the same facility.

In addition to various TAD assignments aboard aircraft carriers, part of LCDR Herzog's assigned duties as a member of the anesthesia department at Portsmouth, was that of fleet anesthesia readiness officer. This involved evaluating the appropriateness and capabilities for anesthesia service aboard various naval vessels including LHA's and LPH's. "Both this collateral duty and that of clinical coordinator for nurse anesthesia school were very challenging and most rewarding for me." Following his tour at Naval Hospital, Portsmouth, Herzog was assigned for 14 months to USS *Nimitz* and deployed with this carrier to the Mediterranean. When the *Nimitz* arrived at Bremerton, Herzog transferred to the Naval Hospital to serve as a staff nurse anesthetist. "My anesthesia career in the Navy has been truly rewarding personally and professionally. I have received a great deal of support from fellow Nurse Corps officers and physicians. What I would like to convey as part of my 80th anniversary message is this: "Every nurse needs to make a firm, highly regarded decision as to what they want to do, what avenues they need to explore, and professionally what they need to do to prepare themselves for what it is they want. Goal-setting, hard work, and tenacity are essential. Admittedly, luck and timing have a little to do with it as well. I think that people make their own way in the Navy Nurse Corps. If there is something you want, you must set a goal and work very hard to achieve it. The bottom line is that nobody in the Nurse Corps, in the Navy, or in life for that matter is going to hand you anything on a silver platter. The Navy will provide the opportunities, but ultimately it is up to the individual." □



LCDR Todd Herzog

LCDR Barton is assistant for Nurse Corps matters (OP-093N2) on the staff of the Surgeon General, Washington, DC.



LCDR John Griffin

Daisy Vidro (left), Marisol Arce, and Emmanuel Borrero (right) attend to a patient at Naval Hospital, Jacksonville.

Nursing Co-Op

A New Source for Navy Nurses

It was a chilly January afternoon when they arrived, six travel-weary nursing students from Puerto Rico. They were the pilot participants in an exciting program that would offer them experience in their chosen profession, and provide reinforcements for an overworked nursing staff at Naval Hospital, Portsmouth, VA. Acclimatizing themselves to winter, a season few of them had ever experienced, was the easy part. Learning a new culture and making Spanish their *second* language would be more difficult. Tougher still would be working long hours on the wards and learning to fit into the hospital routine. Nevertheless, they made the necessary adjustments and in May successfully completed their first 4 months at Portsmouth.

The Navy Cooperative Education Program for Nursing Students has withstood infancy and is now flourishing at Naval Hospitals, Portsmouth and Jacksonville. The co-op program is one solution for the Navy's acute nursing deficit, a shortage that is also being felt in the civilian community. Recent statistics show that the vacancy rate for registered nurses in civilian hospitals more than doubled between 1985 and 1986. As the rate increased from 6.3 to 13.7 percent, nursing school enrollment decreased at a rate of 10 percent per year for the past 3 years.

To stem the tide, civilian institutions have been aggressively recruiting both inside and outside the country. The Navy, with its co-op program, is limited to recruiting U.S. citizens, but the sources, although not limitless, are indeed promising. "Women in nursing are not underrepresented, but minority women are," points out Louisa Castro, the Naval Medical Command's Equal Employment Specialist, Command Hispanic Program Manager, and a key member of the co-op recruitment team. If other minorities such as blacks, Hispanics, U.S. citizens of Asian and Pacific backgrounds, and Native Americans are also underrepresented in the Navy, wouldn't it make sense to target those groups and address two of the Navy's chief concerns—the nurse shortage and minority underrepresentation?

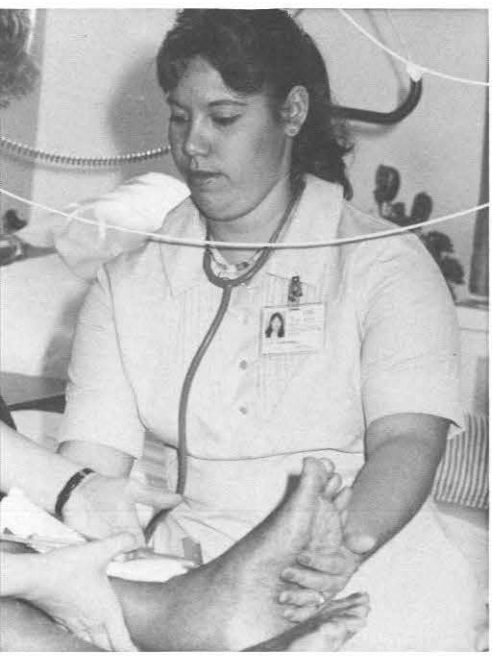
Fortunately, the nurse co-operative program did not have to emerge from a vacuum. Several Federal agencies have used co-op education programs to fill specific billets and meet Federal equal opportunity recruitment goals. However, no cooperative education programs for nursing students existed in either the private sector or in any of the other military services. The Navy's Centralized Cooperative Education Program has been very successful in acquiring engineers and computer specialists, and for that reason the Naval Medical Command relied on that office's expertise to get the nurse co-op off the ground. What the command envisioned and what has been developed is a work-study program whereby a student alternates 4 months or a semester for full-time academic study with employment in a naval hospital.

In August 1985 NAVMEDCOM and the Centralized Cooperative Education Program manager began to implement the program involving Hispanic baccalaureate nursing students. The initial objective was to increase the number of entry level civilian nurses while simultaneously decreasing severe Hispanic underrepresentation. Visits to college campuses with high Hispanic student populations

elicited considerable interest both by administrators and students. Schools included the University of Puerto Rico at Mayaguez and Arecibo, the University of Texas at El Paso, the University of New Mexico at Highlands, and New Mexico State University at Las Cruces. The team not only met with students but also with university co-op program managers and nursing school deans.

But as well as the concept was received, building a good working relationship with a school required the laying of a solid foundation and years of intense negotiations to work out details. "It took 3 years before we were satisfied that the University of Puerto Rico could meet our requirements," recalls Mrs. Castro.

What were the requirements and what other obstacles had to be overcome? The school had to be accredited by the National League of Nursing, and administer the National Council for Licensure Examination for Registered Nurses (NCLEX-RN) tests to its graduating students. How would a student complete the required nursing curriculum while at the same time working in a naval hospital? If the student missed a semester, how could he/she make up the courses missed?



Student nurse Marisol Rivera (Portsmouth) assists a patient on skeletal traction.

Key to the program was the Navy's insistence that the students graduate on time. Although Puerto Rico has five nursing schools, thus far only two can fulfill this requirement—the University of Puerto Rico at Mayaguez and Catholic University at Ponce. As a result, these turned out to be the pilot schools for the nurse co-op program. The pilot hospitals—Portsmouth and Jacksonville—prepared to receive their first students in January 1988. The recruiting team made yet another trip to Puerto Rico to interview the candidates.

The Mechanics

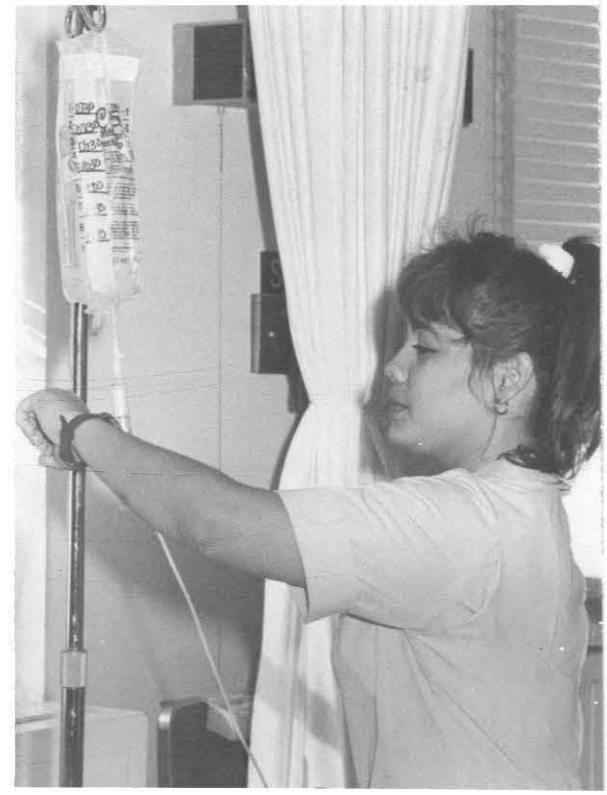
What students are eligible? A nursing student must:

- Be in his/her second or third year.
- Be a U.S. citizen.
- Have a grade-point average above 2.5.
- Be recommended by the university's cooperative education program director.
- Meet academic standards required by the Naval Medical Command.
- Be accepted by the employing hospital.

The Navy Centralized Cooperative Education Program pays the student's tuition, travel, fees, and books. He/she receives a salary and work experience during the work-phases at the employing naval hospital. Upon successful completion of two work phases alternating with two periods of academic study, and no less than 120 days after graduation with a B.S.N. degree, the former student is converted to a civilian nurse position at a GS-7 with a starting salary of $18,726 and is assigned to a naval hospital to complete a 1-year obligation. If the student meets the requirements for entry into the Navy Nurse Corps, he/she may also exercise that option.

While in school, he/she is on a Leave Without Pay (LWOP) status but, after arriving at their hospital for the 4-year work phase, they receive a GS-4 salary as a civilian employee. Each student is assigned a supervisor or nurse preceptor. Following initial orientation, each student begins to work on his/her preceptor's work schedule. Students are assigned to night, day, or rotating shifts and wear the uniforms of their own nursing schools while on duty. The first work phase emphasizes medicine and surgery, and students are expected to handle routine nursing procedures. In the second work phase students may be assigned to specialty care areas based on the needs of the facility.

Photos by HM1 Wanda Vaughn-Taylor



Yasmin Suarez (Portsmouth) adjusts a patient's IV rate.

Both Portsmouth and Jacksonville contingents are now back in Puerto Rico completing the second semester of the junior and the first semester of the senior year. They will return to Portsmouth and Jacksonville in January 1989. For retention in the program, a student trainee will be required to satisfy the academic standards of the university and the work performance standards of the medical facility. If their evaluations merit a

promotion, they will be advanced to the GS-5 pay grade.

As expected, the pilot programs at Portsmouth and Jacksonville are working so well, according to Nurse Corps Specialty Advisor, CDR Kristine Minnick, that other naval hospitals are lining up to get on board. Naval Hospital, Pearl Harbor now has a working student, Guam will shortly receive its first student, participation is planned for Bremerton, Oakland, and San Diego, and efforts are underway to recruit minority nursing students from several Southwestern states.

From the students' viewpoint, the nurse co-op program provides a unique opportunity to work both with civilian and military nurses. A regular nursing student might get 4 or 5 hours a week practicing in a local hospital between classes. A co-op participant gets 4 continuous months working an 8-hour shift. Moreover, if the student has had the idea of becoming a Navy nurse, blind reliance on a recruiter's story is unnecessary; the student will have a true picture of Navy nursing.

What the Navy gets in the end is a better quality nurse, trained within the Navy system and committed to working a full year after graduation. The odds are also good that the Navy will acquire that graduate as a career Nurse Corps officer. Although the nurse co-op program may not offer the ultimate cure for the Navy nurse shortage, it provides one very innovative solution where everybody wins. —JKH

A Man for All Services

Josue Toro is a 31-year-old nursing student with an unusual background. He has already been a marine and a soldier, and now plans on adding the Navy to his list of armed services. At the moment, Toro is back home in Puerto Rico studying nursing at Catholic University in Ponce, having just completed his first 4-month work phase at Naval Hospital, Portsmouth.

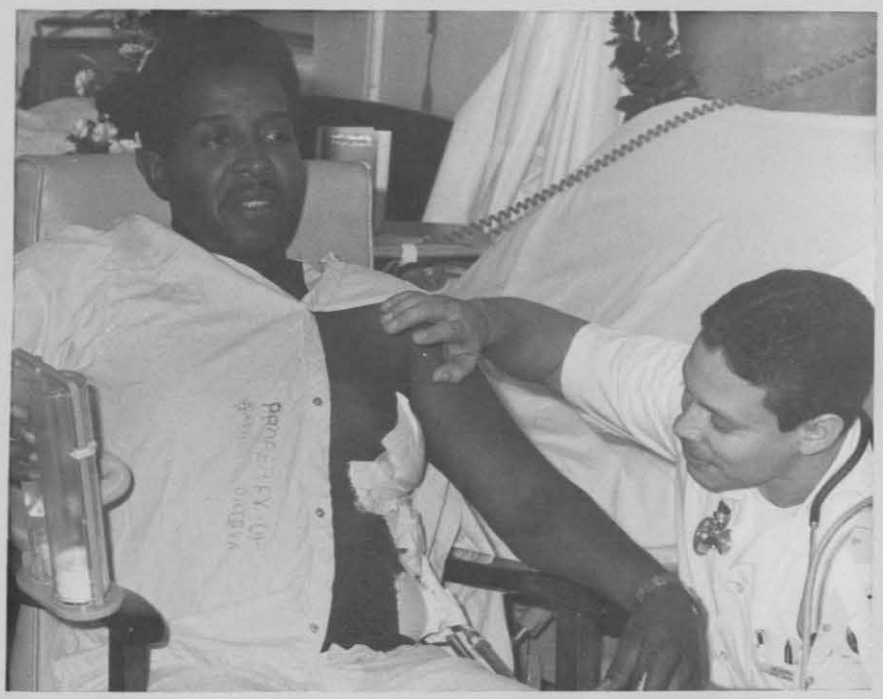
Following graduation from high school in 1976, Toro began studying medicine at the University of Puerto Rico before dropping out to serve a 4-year stint as a radio operator in a Marine recon battalion. He was discharged in 1981, got married, and joined the Army for the next 4 years. While stationed at the U.S. Army Research Institute at Fort Detrick, MD, he worked as a lab technician and practical nurse on an isolation ward.

"That's when I really started liking the nursing field," he says. Noting his skill and aptitude, the physicians he worked with suggested he leave the Army and study nursing.

Toro took their advice and returned to Puerto Rico to study nursing full time. Hard work paid off. He soon made the dean's list and rated an entry in *Who's Who in American Colleges.*

For the last several years, Toro has maintained his association with the Army and is a sergeant in the Army Reserve. As a medical specialist, he drives an ambulance and provides primary life support services in the field.

Toro's selection to the Navy Nurse co-op program inevitably turned his allegiance yet again. He is currently seeking to switch to the Naval Reserve and, following graduation from nursing school, plans to become a Navy nurse. "I want a good future for me and my family," he says. "Being in this program and becoming a Navy nurse is the best way to see it happen." —JKH



Josue Toro (Portsmouth) checks a patient with a chest tube.

A Competency-Based Tool for Evaluating Navy Nurses in the Psychiatric Setting

CDR Margaret Foote Balacki, NC, USNR

Psychiatric nursing is defined as "a specialized area of nursing practice which employs theories of human behavior as its scientific aspect and purposeful use of self as its art . . ."(*1*) Nurse Corps officers assigned to psychiatry without prior training or experience in psychiatric nursing are at a distinct disadvantage until such time as satisfactory clinical competencies are developed. While this may also be true of any specialized area of nursing, the development of clinical competencies presents a particular challenge to psychiatric nursing since in this field the primary tool is the use of self. Clinical competencies may be seen as less tangible than other areas of nursing and therefore less measurable.

In preparing this orientation program, it was felt that psychiatric clinical competencies can be stated in such a way that expectations are very specific, performance is measurable, and an objective evaluation of performance can be carried out. Not only would this be a tool to determine existing clinical abilities, but it would also serve as a clinical abstract to guide future performance.

Review of the Literature

Use of the clinical contract has primarily been in nursing education to assist student nurses in meeting basic clinical competencies.(*2,3*) Competency-based orientation is not unusual in specialized areas of nursing where clinical skills can be tangibly measured.(*4-7*) There was, however, a paucity of identified tools for psychiatric nursing. Hagerty (*8*) recently identified a psychiatric competency-based orientation program. In it she combined administrative and clinical competencies, clinical competencies being both psychiatric and general duty in nature.

The tool does not take into account any differences in education or experience levels addressing only two groups, the R.N. and psychiatric care worker. Perhaps in the civilian setting it can be assumed that clinical and administrative competencies will equate at any given level, but in viewing the unique nature and needs of Navy nursing, it was felt that a clinical competency tool needed to be identified separately from administrative and general functions.

Reprinted from the March 1988 issue of *The Journal of the New York State Nurses Association.*

This article received the 1987 Nielubowicz Award. The award recognizes an original essay by a Navy Nurse Corps officer (active or reserve) which advances military nursing practice.

In developing a competency-based tool for critical care nurses, Alspach(*4*) identified 11 elements of competency-based education. First, she states that it should be based on a board competency area with all segments of the curriculum designed to the broad learning of the individual. Second, it is based in the real world. Objectives are often based in a largely theoretical notion of practice. A competency-based tool originates from what the real performance of competent practitioners in that role actually comprises. The third characteristic is that it is directed as a specific role and setting. This tool identifies performance characteristics at the staff nurse level and then progresses to more advanced clinical performance. Fourth, it is derived through expert practitioners. The bulk of the tool was taken from Haber's competencies for each of the ANA (American Nurses Association) Standards of Practice. Revisions were based on past clinical experience as a Navy nurse. The fifth characteristic is centered on practice/performance outcomes. The outcomes must go beyond knowing to doing things well. Sixth, there should be publicized expectations of learners. The seventh characteristic states that there must be flexibility in instruction. Competencies are an end rather than the means of instruction, allowing the particular department the choice of instructing nurses in required clinical competencies. Eighth, there is publicized expectations of learners. Along with clear expectations, evaluation should be based on criteria rather than a simple peer evaluation as the ninth characteristic. Tenth, it provides for remedial recycling. Evaluations can be done at specific intervals (end of orientation, end of fitness report cycle) with remedial training being offered where required to sharpen lost competencies. And finally, it is learner-centered. The tool, to varying degrees, meets all 11 Alspach's characteristics of a competency-based program with some modification incorporated to meet the unique nature of Navy nursing.

Development of the Tool

In order to effectively orient, clinically and administratively, new Nurse Corps officers into psychiatric nursing, an extensive orientation program was developed. It was decided to have the clinical guidelines as a separate component of the program.

The first assumption in identifying clinical competencies is that clinical expertise, unlike managerial and leadership skills, is not necessarily commensurate with rank. There

are those occasions where preference of the individual or needs of the Navy require that an inexperienced but more senior nurse be placed in a clinical area possibly moving quickly into the role of charge nurse.

Since clinical competency cannot always be based upon rank, it was decided to develop a system to grade clinically individuals based upon education and experience. Psychiatric nurses were classified into one of five groups independent of rank (see box). The classification takes into account Navy subspecialty codes as well as certification by the ANA.

The next step was to identify required clinical skills for each of the five levels. Haber et. al.(*9*) examined each of the 12 ANA Standards of Practice for mental health nursing, advancing certain clinical performance criteria for each. It was found that these could readily be adapted to the particular needs and characteristics of psychiatric nursing at naval facilities. The division of these competencies into five clinical levels was based upon what is felt to be basic psychiatric clinical competencies for a general duty staff nurse progressing to more advanced clinical skills with additional education and experience.

Discussion

While it was originally intended to be an orientation tool for psychiatric nurses of all competency levels, it was found that the tool would also serve as an ongoing clinical evaluation guide and would assist in individualizing performance plans for Nurse Corps officers.

It is not inconceivable that a junior officer may arrive in the department with advanced clinical skills, possibly even surpassing those of more senior nurses. This tool would serve to assist the nurse in a supervisory role to determine reasonable clinical expectations for a particular nurse thus providing a challenging environment which would foster growth.

When writing fitness reports, it is assumed that individuals of equal rank can be compared for leadership and management skills. Clinical competencies are addressed under the category of Goal Setting and Achievement. To compare clinical competencies by rank can create a discouraging atmosphere to new nurses in the department who may actually be achieving very well at their own particular clinical level.

To illustrate this point, two lieutenants may be assigned to a psychiatry department, one a level II nurse and the other a level IV. The level II nurse meets all the competencies for level II and is working toward level III. The level IV nurse is solidly practicing at level III. At face value the latter nurse would seem to be performing at a higher level. Yet, one nurse is underpracticing while the other is setting realistic goals and achieving higher clinical competence. Using this tool, nursing supervisors can individualize clinical performance plans, monitor progress on an ongoing basis, and create for nurses of all ranks a clinically challenging atmosphere that fosters growth in a supportive fashion.

An additional advantage of the use of this tool is that it simplifies the planning of training by the department training officer. Deficient clinical skills become readily apparent as the clinical preceptor collaborates with the training officer to focus training on objectively measured clinical deficits.(*10*) Finally, the tool can also serve as a guide for privileging nurses for more advanced clinical functions such as clinical consultation, supervision, and individual and group psychotherapy.

Classification of Nurse Corps Officers

Level I

Level I is the entry level for all Nurse Corps officers without previous psychiatric experience or education beyond the basic preparation level. This officer generally has some nursing experience in another clinical area and has completed command orientation. Completion of level I qualification indicates sufficient expertise to deliver basic psychiatric nursing care to patients in all inpatient clinical areas in the department of psychiatry.

In general, a 6-week orientation program, under the guidance of a nurse preceptor, is required to accomplish the skills necessary for a level I nurse as outlined on the clinical assessment sheet. The length of this program may be adjusted according to the individual needs of the nurse. No subspecialty code.

Level II

The level II Nurse Corps officer arrives in the psychiatric nursing department with up to 2 years of psychiatric nursing experience and/or some formal training beyond the basic preparation in nursing education. In addition to all level I skills, he/she is expected to demonstrate an advanced level of knowledge and skill consistent with this experience level.

The officer with more extensive psychiatric nursing experience gained at a civilian facility is considered to be a level II nurse until such time as the principles of military psychiatric nursing have been incorporated into nursing practice. Orientation for level II will be approximately 4 weeks. No subspecialty code.

Level III

The level III Nurse Corps officer has significant knowledge and experience gained through military

Results

At the end of a 1-year period, three Nurse Corps officers had been oriented to the psychiatry department using the development orientation program. While the clinical competency tool was not being used for ongoing evaluation purposes, it did serve as a self-monitoring device for the individual nurses to determine what was realistically expected of them for their particular clinical level. While only one of the three nurses would be considered a level I nurse, all three responded positively to the orientation program.

The bulk of the educational materials contained in the orientation program was geared to the level I nurse yet all three felt the program was extremely worthwhile. Perhaps when expectations are made clear at any level, nurses are made to feel more secure in their clinical performance.

Conclusion

This competency-based tool has had only a very limited testing period and only with three orientees. Its value to psychiatric nursing coordinators and those who plan training can be determined only after a longer period and with larger numbers of nurses. With greater use, some clinical supervisors may feel that certain clinical competencies belong at one level rather than another.

The tool can be modified to meet the needs of any particular psychiatry department and the clinical expectations of the nursing coordinator. The important fact is that clinical expectations are clear, fostering an atmosphere of support and growth. Individual performance plans are developed independent of rank, challenging each nurse regardless of clinical level of expertise. In particular, it will meet the pressing needs of the more senior, less experienced, Nurse Corps officer working in psychiatry either by choice or to meet urgent department needs at a given location. In a supportive, learning environment these nurses can quickly become valuable members of the mental health treatment team.

A copy of the tool can be obtained from the Nursing Office, Naval Medical Command, Washington, DC, for those who would like to participate in further testing the tool and providing input at a later date.

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or military and civilian practice as well as some training in psychotherapeutic nursing interventions. This formal training can be in the form of courses and seminars or an advanced degree in a related field.

In addition to the skills required for level I and II, the level III nurse is expected to assume a clinical leadership position in the nursing department, sharing skills and information with other members of the nursing care team and ensuring that the delivery of psychiatric nursing care in his/her area of responsibility meets the highest standards of nursing practice.

The level III nurse demonstrates advanced clinical skills in the delivery of nursing care to the psychiatric patient. Orientation should be accomplished in approximately 2 weeks. Level III officers are expected to hold a B.S. in nursing. Subspecialty code is 1930s.

Level IV

The level IV nurse is an American Nurse Association certified practitioner and has demonstrated advanced clinical knowledge and expertise. Clinical experience has been within the past 2 years and orientation should be accomplished in 2 weeks. Subspecialty code for the certified practitioner is 1930k.

Level V

The level V nurse holds a M.S. in psychiatric and community mental health nursing and is considered to be a psychiatric clinical nurse specialist. In addition to the direct delivery of nursing care to the psychiatric patient, this nurse has areas of responsibility in consultation, supervision, education, and research. Orientation should be accomplished in approximately 2 weeks. Subspecialty code is 1930p.

Trends in Morbidity and Use of Health Services by Women Veterans of Vietnam

LCDR Diane M. LeDonne, NC, USN

Considerable research(*1-7*) has focused on the emotional and physical problems of male Vietnam-era veterans, particularly the effects of combat and posttraumatic stress disorder (PTSD). Comparable attention to the women who served during this era has not occurred, even though women were assigned in Vietnam and exposed to the full realities of war. In fact, very little other than a few isolated personal narratives(*8-11*) about their experiences were available until recently, when several anecdotal collections(*12-14*) appeared. Empirical studies of the long-term effects of combat exposure on women are also beginning to appear,(*15-17*) but so far these have been limited to the examination of PTSD, not physical effects.

The percentage of women in the military increased from 1.4 percent in 1970(*18*) to 10 percent in 1986,(*19*) with a corresponding upward growth rate in the number of women veterans. Concerned about the adequacy of its health care system to effectively meet the needs of this rapidly growing segment of the veteran population, the Veterans Administration commissioned Louis Harris and Associates, Inc. to conduct the Survey of Female Veterans (SFV). Because women from the Vietnam era were included, it was finally possible to examine this segment of the veteran population.

TABLE 1
Vietnam-Era Women Veterans Assigned in Vietnam Exposure to Combat (N=28)

Served in a designated war zone	21
Served in a combat zone	18
Flew over a combat zone	16
Received incoming enemy fire from artillery, rockets, or mortars	15
Received sniper fire	14
Saw Americans killed or being wounded	13
Experienced bombing attacks	6
Present during full-scale attack	5
Wounded	1
Prisoner of war	0

Method

The SFV is a national cross-sectional survey of 3,003 noninstitutionalized women veterans, conducted during late 1984 and early 1985. It resulted in a wealth of demographic, economic, health service use, morbidity, and attitudinal data about women veterans from all eras of service.(*20*) The SFV includes data from 720 women Vietnam-era veterans, 4 percent (N=28) of whom were assigned in Vietnam. Secondary analyses of the SFV for this and a larger study to be reported elsewhere consisted of both descriptive and inferential statistical methods.

The percentage of women Vietnam-era veterans who had actually been assigned in Vietnam is consistent with national estimates. However, the small sample size limits the types of appropriate statistical analyses as well as the extent to which findings can be generalized. In addition, computing percentages on a sample size of fewer than 100 can be misleading. With these caveats in mind, some interesting trends in the data did emerge.

Profile

Of 28 women who were assigned in Vietnam, 21 were exposed to some type of combat situation (Table 1). The majority served in a combat zone as well as the designated war zone, flew over a combat zone, received incoming enemy fire from artillery, rockets, or

A Navy nurse tends a patient in the hospital ship *Repose*'s ICU during Vietnam era.

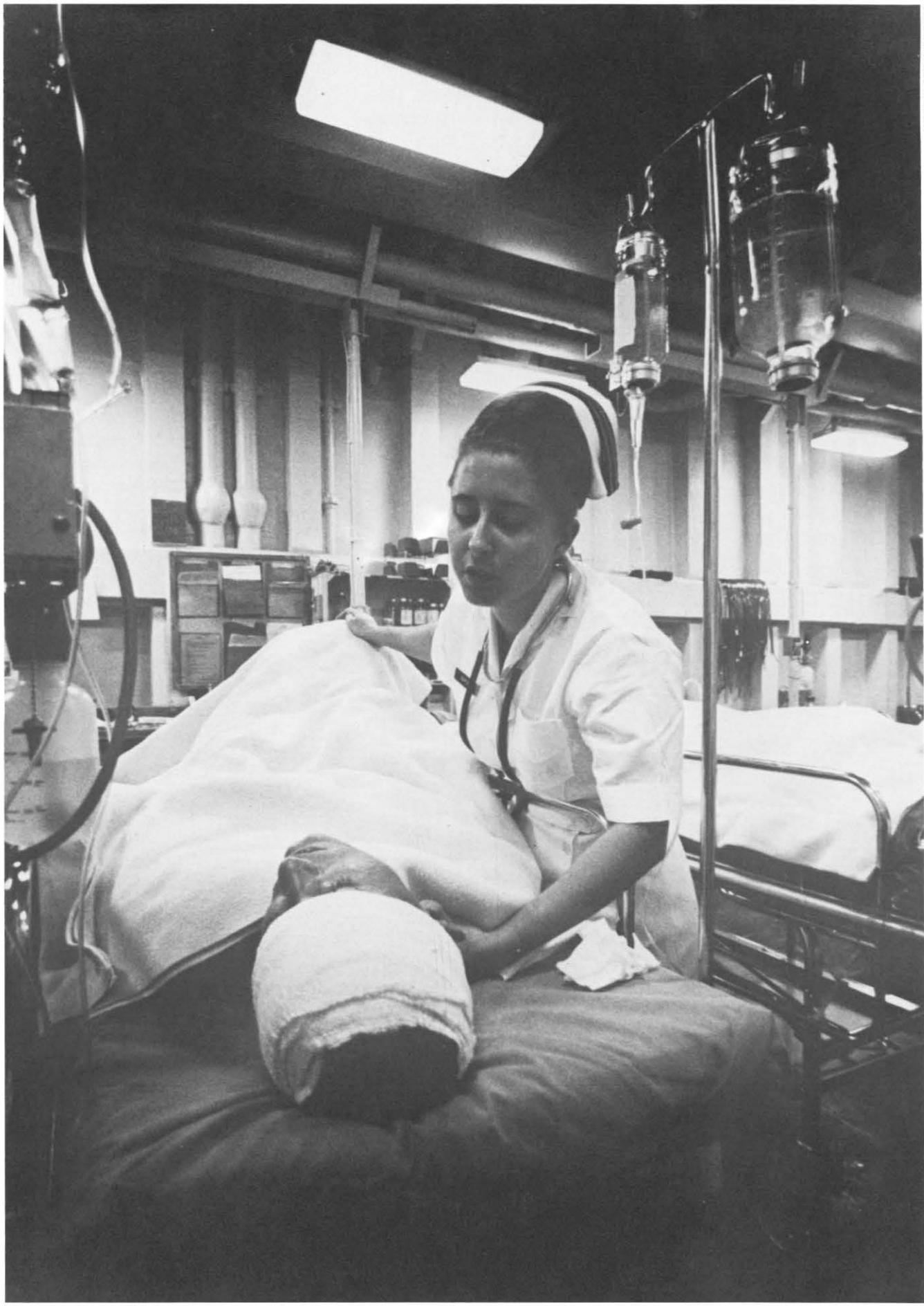

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TABLE 2
Comparisons of Morbidity for Women Veterans Who Were Assigned in Vietnam and All Vietnam-Era Women Veterans (Raw Frequencies)

	Vietnam Assigned (N=28)	All Vietnam Era (N=720)
	Percent	*Percent*
Acute illnesses past year	16 (57)	406 (56)
Chronic conditions past year	15 (54)	350 (49)
GYN conditions past year	11 (39)	238 (33)
Told had cancer	3 (11)	36 (5)
Have a disability	10 (36)	154 (21)
Given birth	15 (54)	521 (72)
Child born with defect	5 (33)	84 (12)
Child died before first birthday	1 (7)	31 (4)
Miscarriages	9 (32)	228 (32)

TABLE 3
Comparisons of Morbidity for Women Veterans Who Were Assigned in Vietnam and All Vietnam-Era Women Veterans (Means)

	Vietnam Assigned (N=28)	All Vietnam Era (N=720)
Acute illnesses past year	1.9	1.7
Chronic conditions past year	2.6	1.9
GYN conditions past year	2.9	1.6
Live births	2.3	2.0

mortars, received sniper fire, and saw Americans killed or wounded.

Most of the women who had Vietnam assignments were officers, including 16 nurses. The majority are Caucasian, aged 35-44, employed, and have household incomes of between $30,000 and $35,000 a year. Less than half are currently married and slightly more than half have ever had a baby. One of them served in the military for 31 years. The average length of service for the other was 4.5 years. Five have a service-connected disability rating.

Morbidity

Was the morbidity of women Vietnam-era veterans affected by assignment in Vietnam? Many similarities are obvious in the morbidity patterns of the women Vietnam-era veterans who were assigned in Vietnam and the full sample of Vietnam-era women (Tables 2 and 3), and the women Vietnam-era veterans who were only assigned in the United States during their military service (Table 4). Specifically, no remarkable differences are seen in the percentage of those who had an acute illness, GYN condition, or miscarriage.

However, three interesting differences are observed. First, a higher percentage of those who were assigned in Vietnam have chronic conditions and disabilities, and they have more of them. Second, a higher percentage have been told they have cancer. Third, although a smaller percentage of Vietnam-assigned women ever had a baby, a higher percentage of those who did have children born with defects and/or die before their first birthday.

Health Services

Was the use of health services by women Vietnam-era veterans affected by assignment in Vietnam? The annual health services use of women who were assigned in Vietnam was contrasted with that of the full sample of Vietnam-era women veterans (Table 5). A higher percentage of the Vietnam-assigned women visited a physician and a higher percentage were hospitalized. However, the average number of physician visits during the year was identical for the two groups.

Discussion

These are the first analyses of the morbidity and health services utilization of the women who were exposed to combat situations in Vietnam. The findings are interesting because they support longstanding concern and speculation about long-term physical effects from the stress associated with exposure to combat situations. As noted in numerous accounts,(*8-17*) and supported by the SFV data, women in support roles in Vietnam were frequently exposed to some of the same combat situations as the men. In

addition, particularly for the nurses, there were other types of stressors, specific to the nature of their work.

Women have served usefully and honorably in nursing and other support roles in combat areas since the time of Nightingale. Knowledge of both short- and long-term physical as well as psychological effects is important for designing postexperience screening and monitoring regimens, as well as access to appropriate types of treatment alternatives.

As noted earlier, the findings are tentative because of the sample size. Replication with a representative and sufficiently large sample of the women who served in Vietnam (including those still on active duty) could verify the trends observed in this study.

TABLE 4
Vietnam-Era Women Veterans Comparisons of Morbidity for Vietnam and USA Assignment (Raw Frequencies)

	Vietnam Assigned (N=28)	Only USA Assigned (N=478)
	Percent	*Percent*
Acute illnesses past year	16 (57)	275 (58)
Chronic conditions past year	15 (54)	226 (47)
GYN conditions past year	11 (39)	164 (34)
Given birth	15 (54)	371 (78)
Child born with defect	5 (33)	59 (16)
Child died before first birthday	1 (7)	20 (5)
Miscarriages	9 (32)	161 (34)

TABLE 5
Comparisons of Health Services Use for Women Veterans Who Were Assigned in Vietnam and All Vietnam-Era Women Veterans (Raw Frequencies and Means)

	Vietnam Assigned (N=28)	All Vietnam Era (N=720)
Physician visits past year	22 (79 percent)	503 (70 percent)
Physician visits past year	3.7 (mean)	3.7 (mean)
Hospitalized past year	8 (29 percent)	114 (16 percent)

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HIV Program at Bethesda

Diane LaMacchia

By the end of an 8-hour day, Patrick Cunningham is dreading his ride home on the subway. "I'm tired, I'm dragging," Cunningham tells his doctor. Even starting out in the morning can be difficult. "On Monday mornings I'll sit on that metro train and feel like I just ran a 10K."

Cunningham is a former active duty member who is now on the Temporary Disability Retired List (TDRL). He discovered he was positive for antibodies to the human immunodeficiency virus (HIV) the day he had planned to get out of the Navy in April 1986. Now he works for the Federal Government as a civilian office manager and worries that he misses too much work when he goes to Bethesda for treatment. He is on AZT, or zidovudine, an FDA-approved medication used for treatment of HIV disease.

"Are you having a problem sorting out what's psychological and what's physical?" his doctor asks. Cunningham is at Bethesda for Tuesday morning HIV clinic. CAPT Kenneth F. Wagner, MC, head of the infectious diseases division, is spending time with Cunningham this particular morning.

Yes, Cunningham says. It's hard to tell if he actually has memory loss or he's preoccupied and depressed knowing he has a deadly disease. "There is a certain lack of enthusiasm about getting out of bed," he says.

Cunningham is one of about 500 patients, mostly men, who have been through the HIV program at Bethesda since its beginning in late 1985. Like the others, he has been given a tremendous amount of information about the disease but feels that he can never know enough. There is so much that is unknown about the infection and effects of various treatments.

"Our patients that leave here are as educated as most GP's about HIV disease," Wagner says. "You'd be surprised—these guys have researched the hell out of this."

The Navy is in its second round of screening all members for exposure to the human immunodeficiency virus. The HIV program is designed to provide medical evaluation for HIV seropositive individuals as well as education, counseling, and subsequent medical disposition for them, according to CAPT David B. Wilson, MC, head of the HIV branch of the infectious diseases division. "We've branched into medical treatment and followup as necessary," Wilson says.

The idea is for the patient to see the same physician for evaluation and followup, but that is not always possible. Being unable to see the same physician is one of Cunningham's major complaints about the program. "It's very disappointing when you go there and you have to explain everything over and over," he says. The doctors are "my only link for survival," he says. Lack of resources is an ongoing problem. "We have a very large program, but very few doctors," Wagner points out.

While the patient is undergoing evaluation, Bethesda offers a 2-week program of courses and support groups. The courses include lecture/discussions on safe sex, religious and family issues, medical aspects of HIV infection, stress and immunology, preventive medicine, and substance abuse prevention. Legal assistance is offered.

The safe sex course is a popular one.

Photos by HM2 Bill Williams

Social workers Denise Gordon (left) and Peggy Davis lead a patient support group meeting on the HIV ward.

It is a graphic instruction on how to keep the disease from spreading to others and how to avoid further infection. Its teacher is a corpsman peer counselor who tested positive for HIV 3 years ago. The safe sex class is held in a sunny conference room on the ward.

"It's a helluva responsibility being placed on our shoulders to stop the spread of this disease. But we have to do that," he cautions the patients. He stresses that sex must be between informed, consenting adults. "You do not have the right to govern someone else's life," he says. A sexual partner must be told about the infection before intimate contact.

The peer counselor, who has been a psych tech for 8 years, attended a lecture in Bethesda's auditorium in 1985 after he had been told he was HIV positive. But the only support group at that time was for staff working with HIV patients, not for the patients themselves. "I spoke to the lady afterwards," he said. She introduced him to Roger Roark, who was the head of the social work department at the time. The result of their meeting was the establishment of a support system for the patients. "The one thing that makes this work is the peer support," the psych tech says.

Peggy Davis is the social worker who has run the social work part of the program since February 1986. When she started, it was with a group of 30-50 recruits. "They were all over the hospital" Davis recalled, "not receiving our services." The ward was dedicated to HIV patients and "the Navy has made much more of a commitment now to support this program."

Davis belongs to a group of social workers from major hospitals in the Washington area. The group includes social workers from the National Institutes of Health, George Washington University, Georgetown University, Children's Hospital, Washington Hospital Center, and the Veteran's Administration. "Nobody has an education program like we do," Davis says. "The people in our system get treated in a much better and more comprehensive way than in the civilian community."

Cunningham agrees. "I have a feeling it's one of the best," he says. "There's an incredible support system. I think they really did a good job at that." Cunningham has gone beyond the Navy's program for support. He sees a psychotherapist individually and is involved in a protocol at NIH. He belongs to a group at Washington, DC's, Whitman Walker Clinic. "We talk about death, but we're one of the few groups who are not dying with AIDS, we are living with it," Cunningham says.

What happens to a Navy member who tests positive for HIV infection? "When we're absolutely convinced they're positive," says CAPT Wagner, their commanding officer or medical officer calls them in and informs them of the test results.

First, though, the result of the confirmatory Western Blot test comes to Bethesda and the result is sent to the Naval Medical Command. From there, to maintain confidentiality, a letter is sent "eyes only" to the individual's commanding officer, asking that he or she be notified. The patient then comes to Bethesda (or other evaluation center) and is admitted to the hospital and HIV ward.

"We do not have enough nurses to staff that ward," Wagner says. So

HM2 Stephen Lary interviews a patient to learn about the epidemiology of the disease.

those patients who are ill are sent to the internal medicine ward. Internal medicine notifies the HIV program that an HIV patient is there, and someone from the HIV program goes over to see them right away. If they are not ill—which is usually the case—they spend 48 hours or less on the HIV ward and are released to the medical holding company or back to their homes if they live locally. Those that are from out of town are assigned work to do in the hospital so they can keep busy while awaiting results of their evaluation.

People that live close by often get out on the same day they are admitted and "nobody on their job even knows why they're gone," Wagner says. People on the job knowing or not knowing they are gone or why they are gone is a big issue for the patients. It comes up in the daily patient support groups and in conversation in the ward's TV lounge. "I don't want to be talked about behind my back," one man says. Another man, at Bethesda for his third evaluation, says only "a few key people" at his command know why he has gone to Bethesda. "But there are some horror stories," he says. "It really kind of centers around that CO and how he feels about the whole thing and how he considers confidentiality."

A young marine sergeant, at Bethesda for his annual reevaluation, says one of the hardest things for him "is dealing with your coworkers and not letting them know what's going on. They want to know where you're going. It's something you can't just tell everyone."

If they knew he had tested positive for HIV infection, "most of them would probably think that I was gay. Second, they wouldn't look at it as HIV—they'd say 'He has AIDS and he's going to die.' I worry am I or am I not going to get it. That's what I worry about."

The marine sergeant had arrived at Bethesda from his Naval Air Station at 0700. He checked in with admissions, got his orders stamped, and came up to the ward to fill out paperwork, including some questionnaires. By 0900 he has been interviewed by a civilian employee in the preventive medicine department. Basically, he says, it is the same routine he went through a year ago.

He goes to radiology for X-rays and waits only a few minutes. He is taken first because he's in uniform. Back up on the ward he has an appointment with Mary Matson, the ward nurse. She asks him what stage he was when he was first evaluated, referring to the DOD staging of the disease which includes stage I through stage VI. Has he had any symptoms such as headaches, night sweats, diarrhea, or nausea? No, he says.

"Are you able to accept the illness?" she asks. Yes, he says. She asks about his attitude toward the future. He's not sure whether he'll reenlist in the Marine Corps or not. He does not like his current duty station. Does he have concerns and fears about the illness? Yes, he says. He wants to know if it will develop into AIDS.

That is a question no one has a sure answer for. But chances are, the disease will progress. As Cunningham says, "Clearly, medical evidence is that everybody who has gotten the virus has gotten AIDS."

After lunch, HM2 Stephen Lary spends 45 minutes with the young marine, interviewing him as part of the Navy's attempt to understand the epidemiology of the disease. The purpose of the "epi" study, says Wilson, is to determine the natural history of HIV infection. Patients are interviewed to find out where they got it, where they have been with it, and prior exposures.

"We make it as easy as possible on the patient because they have to go through so many questions in the course of the evaluation," Lary says. There is a three-page anonymous section to the questionnaire which the patient is asked to mail in. It asks questions about numbers of sexual partners by geographic location and

whether any had AIDS, whether the patient has used intravenous drugs, numbers of sexual encounters during deployments, etc. The rest of the form asks for demographic information, lists of past diseases and illnesses, living habits, and current symptoms.

"Being involved in such a prominent medical issue today is exciting," Lary says. "Every day you see something on TV about it. I've met a lot of good people and I've learned a lot about people" working in the HIV program.

After the epidemiology interview, the patient walks to the blood laboratory and gives nine tubes of blood for testing. Tests will include a complete blood count, lymphocyte count, total T-cell count, and absolute CD4 and CD8 levels. The lab technician wears gloves and disposes of the used needles in a special marked and sealed "dirty needle box."

Back on the ward, the marine has an interview with social worker Davis. She asks him how he feels about coming back and if he has talked to his family about his health. She encourages him to attend the courses again, especially the ones on safe sex, medical information, and stress. He agrees to attend some courses and also go to the support group.

His skin tests for delayed hypersensitivity and his physical exam are scheduled for the next day. After he goes through the entire evaluation, his physician will write a medical board referring him to the Central Physical Evaluation Board, which will decide whether he will continue on active duty or be placed on the TDRL or the Permanent Disability Retirement List. TDRL will usually be recommended if he has any symptoms of the disease, such as thrush, low levels of T-helper cells, hypoergy or anergy, or progressive clinical illness such as neurologic disease, secondary cancers, chronic infections, or constitutional diseases.

Patients who are placed on TDRL—patients like Cunningham—continue to receive treatment. Cunningham comes to Bethesda twice a week, once to the HIV clinic, where he discusses his latest test results with his physician, and once to the AZT clinic. He is also free to check in with the social workers and attend support groups or educational activities.

Some patients decide to go home and be with their families for the time they have left. Wagner examined one young man who had come in for followup. "You're beyond the point where we would allow you to be on active duty," Wagner says. The petty officer is 31 years old.

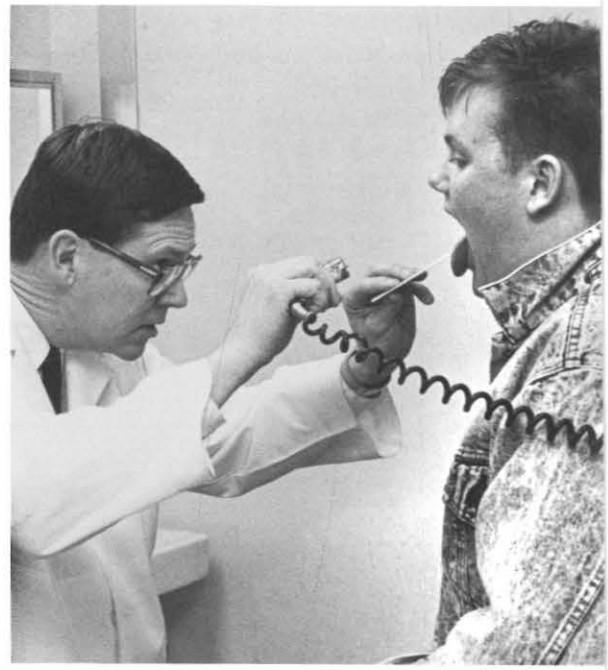
"I didn't know anything was wrong with me until I broke out in this rash," he says, ruefully. He says he might have become infected in Africa. "I've been to Africa seven times." Wagner examines the inside of his mouth and finds ten or more canker sores or ulcers. "You need to start seriously thinking about going on AZT," Wagner advises.

The petty officer is from Lexington, KY. He wants to go home. Dr. Wagner says, fine, but "make sure you have a name to go to when you get to that VA (Veterans Administration Hospital) in Lexington." Wagner volunteers to set up his first appointment for him and suggests that if the VA won't give him AZT, the University of Kentucky may be an alternative.

The young man is optimistic about his future even though Wagner has just advised him he may have only 2 years to live. "I have a desire to have my own catering business," he says. He has paid the mortgage on his mother's house and plans to finish the basement and work out of there. "I've got a feeling I'll be pretty busy," he says.

He will never forget his family's reaction when he first discovered he was infected. "When I called my mother, she said, 'You're talking too much. Get off the phone; I'm on my way.' The whole time I was in the hospital, I was never by myself."

The Navy's HIV program has also been a help. "This program is very informative, very helpful. "I can educate my family, my friends, and the people who have the wrong attitude about AIDS," based on what he learned in the program and his own experience.



Dr. Wilson examines a patient's mouth for thrush.

"The media blew it all out of proportion," he continues, "saying, 'AIDS kills.' The media doesn't talk about HIV and the difference between that and AIDS. They don't tell people about how AZT is working. They just kept saying AIDS, AIDS, AIDS."

Like Patrick Cunningham and others in the program, this young petty officer is striving to live with his HIV infection. A friend once told him he had to. "I had a friend that died about 3 years ago," he says softly. "He told me if I ever contracted the disease to get up as long as I had breath in my body." □

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